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ANTICOAGULATION MANAGEMENT CLINIC REFERRAL

FAX to: ☐ JPOCSC Central Intake (604-953-9701)

PATIENT INFORMATION:

Patient's Name: _____ (Last) _____ (First) _____ (Middle) **Gender:** _____

Date of Birth: ____/____/____ (DD/MM/YYYY) **PHN:** _____ **Insurance:** _____

Address: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Contact Method Primary: _____ **Alternate:** _____

REFERRAL INFORMATION:

Priority: ☐ Routine ☐ Urgent

Referring Health Care Provider:
Name: _____
Title: _____ **Source:** _____
MSP #: _____
Phone: _____ **Fax:** _____

Reason for Referral: _____

_____

Medical Reason for Urgency: _____

_____

Relevant Medical History: _____

_____

Isolation precautions ☐ Airborne ☐ Contact ☐ Droplet ☐ None

Interpreter Required ☐ No ☐ Yes If yes, specify language _____

Referral Clinic: Anticoagulation Management Clinic

This referral form, when completed, is a medical referral to a medical consultant of the Anticoagulation management (ACM) Clinic. Signing this form authorizes the ACM Clinic to order and check laboratory tests pertaining to anticoagulation, order anticoagulants, adjust warfarin to achieve target INRs, to use oral Vitamin K for reversing warfarin therapy, and to implement subcutaneous low molecular weight heparin bridging therapy when appropriate. (see ACM Clinic Scope of Responsibility)

Referring Health Care Provider Signature: _____ **Date:** _____

Primary Care Provider/ Family Physician

Name: _____ **Phone:** _____ **Fax:** _____

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MSXX104191F Rev: Jun. 13/17

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INDICATION(S) FOR INITIATION OF ANTICOAGULATION THERAPY:

☐ Deep Vein Thrombosis ☐ Pulmonary Embolus ☐ Thrombosis (other)_____

☐ Only for Atrial Fibrillation or Valvular Heart Disease patient referrals, call 604-582-4554 PRIOR to discharge. Referral acceptance will be on a case-by-case basis, reserved to help facilitate hospital discharge for patients requiring anticoagulation management and not having access to a primary health care provider.
Instructions to Central Intake: confirm referral acceptance with ACM prior to booking.

TARGET INR RANGE:

☐ 2 to 3 ☐ 2.5 to 3.5 ☐ Other If other, please specify: _____

DURATION OF THERAPY:

☐ 3 months ☐ To be suggested by ACM
☐ Indefinite ☐ Other If other, please specify: _____

ANTICOAGULANT:

☐ Low Molecular Weight Heparin ☐ Warfarin ☐ Other _____

☐ Warfarin and Low Molecular Weight Heparin (i.e. bridging therapy until INR therapeutic)

Warfarin Start Date: _____ Dose(s) already given: _____

Date						
Dose						